New York State Department of Health
Division of Home and Community Based Care

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

ALL SPACES MUST BE FILLED OUT

Facility Name: _____ **Date:** _____

Patient's/Resident's Name: _____

Present Home Address: _____
Street

_____
City State Zip

DOB: ___ /___ /____ **Sex:** Male_____ Female_____
M D Y

Reason for evaluation: ☐ Pre-Admission ☐ 12 month ☐ Acute change in patient condition
☐ Hospitalization/DX ☐ Other Describe: _____

Vital Signs: BP: _____ T: _____ R: _____ Pulse: _____ Height: _____ Weight: _____

Allergies: ☐ No Known Allergies Known Allergies: _____

Primary Diagnosis(es): _____ _____ _____

_____ _____ _____

Secondary Diagnosis(es): _____ _____ _____

_____ _____ _____

Tobacco Use: ☐ Yes Type/Frequency: _____ ☐ No

Alcohol Use: ☐ Yes Amount/Frequency: _____ ☐ No

Non-prescribed drugs:
☐ Yes Type/Amount/Frequency: _____ ☐ No

Mammogram: ☐ Yes Date: _____ ☐ No **PSA:** ☐ Yes Date: _____ ☐ No

Pap Test: ☐ Yes Date: _____ ☐ No **Colonoscopy:** ☐ Yes Date: _____ ☐ No

Activities of Daily Living (ADLs)

Does the patient need the assistance of another person to perform the following ADLs?

ADL	Needs assistance
Ambulate	No ☐ Yes ☐ Intermittent ☐ Continual
Transfer	No ☐ Yes ☐ Intermittent ☐ Continual
Eat	No ☐ Yes ☐ Intermittent ☐ Continual

Diet: ☐ Regular ☐ No added salt ☐ No concentrated sweets ☐ Mechanical soft ☐ Pureed

Other: _____

Continence:

Bladder ☐ Yes ☐ No
If no, how is the incontinence managed? _____

_____

Bowel ☐ Yes ☐ No
If no, how is the incontinence managed? _____

Prosthesis: ☐ No ☐ Yes (describe) _____

Amputation: ☐ No ☐ Yes (describe) _____

Activity Restrictions: ☐ No ☐ Yes (describe) _____

Dependent on Medical Equipment: ☐ No ☐ Yes (describe) _____

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Patient/Resident Name: _____ Date: _____

Pursuant to NYCRR Title 18 487.7(f)(2), the patient is **NOT** capable of self-administration of medication if he/she needs assistance to properly carry out **ONE OR MORE** of the following tasks:

- Correctly read the label on a medication container
- Correctly ingest, inject or apply the medication
- Open the container
- Correctly interpret the label
- Correctly follow instructions as to route, time, dosage and frequency
- Measure or prepare medications, including mixing, shaking and filling syringes
- Safely store the medication

MEDICATIONS: (List all prescription and OTC medications, supplements and vitamins) Attach additional sheet if necessary.

Medication	Dosage	Type	Frequency	Route	Diagnosis	Prescriber (name of MD/NP)	Needs assistance with administration
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

REQUIRED SERVICES: (List all that are needed) Attach additional sheet if necessary.

Medical Evaluation: ☐ Yes ☐ No

Type	Reason	Frequency/Duration	Provided By
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Laboratory Services: ☐ Yes ☐ No

Type	Reason	Frequency/Duration	Provided By
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Home Care: ☐ Yes ☐ No

Type	Reason	Frequency/Duration	Provided By
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

Patient/Resident Name: _____ Date: _____

VISION: Glasses: ☐ Yes ☐ No Glaucoma: L ☐ R ☐ Legally Blind: L ☐ R ☐
Contact Lenses: ☐ Yes ☐ No Cataract(s): L ☐ R ☐

Comments: _____

HEARING: Does the patient have a hearing deficit? Yes ☐ No ☐ Hearing aid: L ☐ R ☐

Comments: _____

SPEECH: Does the patient have a speech defect / impairment? Yes ☐ No ☐

If yes, describe: _____

_____

DENTAL: Does the patient have dental health concerns requiring treatment or which impair chewing/eating?

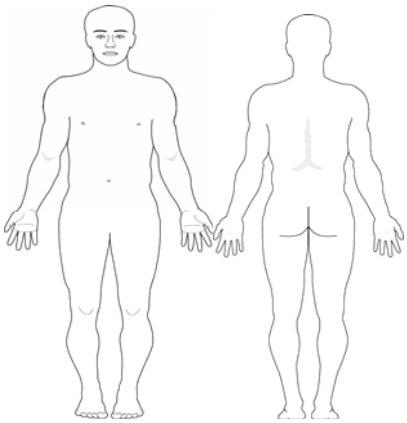
No ☐ Yes ☐ If yes, describe_____

Does patient wear dentures? ☐ No Yes ☐ Upper ☐ Lower

PODIATRIC: Does the patient have podiatric concerns requiring treatment or which impair ability to ambulate or transfer?
No ☐ Yes ☐ If yes,describe_____

SKIN: Does the patient exhibit signs or symptoms of any skin conditions which require treatment, e.g. wounds, bruises, rashes?

No ☐ Yes ☐ If Yes, indicate the type, location and stage of the wound or skin condition on the model below.



A _____

B _____

C _____

D _____

E _____

F _____

PAIN RATING SCALE

Does the patient experience acute and/or chronic pain? No ☐ Yes ☐ Cause of pain: _____

Type (circle): Ache Tingling Burn Throb Pull Sharp Location: _____

Frequency (circle): Intermittent Nightime Constant Duration: _____

Intensity (circle):

0	1-2	3-4	5-6	7-8	9-10
No pain	Mild	Moderate	Severe	Intense	Worst Possible Pain

Treatment:_____

_____

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

Patient/Resident Name: _____ Date: _____

IMMUNIZATIONS AND TESTS **(Recommended but not required for admission.)**

Influenza Vaccine	Pneumoccocal Vaccine	Tetanus Vaccine	Other:_____
☐ Yes - Date: _____	☐ Yes - Date: _____	☐ Yes - Date: _____	
☐ No	☐ No	☐ No	
☐ Unknown	☐ Unknown	☐ Unknown	

Tuberculin Test*

☐ Yes TST1 _____ Date Placed _____ Date Read _____ Mfr. _____ Lot # _____
_____ mm induration

☐ Yes TST2 _____ Date Placed _____ Date Read _____ Mfr. _____ Lot # _____
_____ mm induration

☐ QuantiFERON-TB (QFT) Result _____

☐ No ☐ Unknown

** Required within 30 days of admission unless medically contraindicated.*

Based on my findings and on my knowledge of this patient, I find that the patient _____ **IS** _____ **IS NOT** exhibiting signs or symptoms suggestive of communicable disease that could be transmitted through casual contact.

COGNITIVE IMPAIRMENT/MEMORY LOSS

Does the patient's medical history and/or diagnosis indicate dementia, cognitive impairment or memory loss?

☐No ☐Yes (describe) _____

If the patient is screened for dementia during this examination, indicate the tool used, the date and the patient's score.

Instrument	**Date**	**Score**	**Date of Previous Screen** (if known)	**Score of Previous Screen** (if known)
Mini Mental	_____	_____	_____	_____
Short Portable Mental Status Questionnaire (SPMSQ)	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____

Comments: _____
_____

Based on your examination and/or information from caregivers, do you recommend the patient be screened and/or tested for dementia or cognitive impairment?

☐No ☐Yes (describe) _____
_____

MENTAL HEALTH

Does the patient have a history of or a current mental disability? ☐ Yes ☐ No

Has the patient ever been hospitalized for mental health condition? ☐ Yes ☐ No

If Yes, describe: _____

Based on your examination, would you recommend the patient seek a mental health evaluation?

☐ No ☐Yes Describe: _____

Comments: _____
_____

ASSISTED LIVING RESIDENCE MEDICAL EVALUATION

Patient/Resident Name: _____ Date: _____

STATEMENT OF PURPOSE:
Adult Homes (AH), Enriched Housing Programs (EHP), Residences for Adults (RFA), Assisted Living Residences (ALR), Enhanced Assisted Living Residences (EALR) and Special Needs Assisted Living Residences (SNALR) provide 24-hour residential care for adults. They are not medical facilities. Persons in need of constant medical care and medical supervision should not be admitted or retained in these settings because the facilities lack the staff and expertise to provide needed services. These settings are for persons who, by reason of age and/or physical and/or mental limitations are in need of assistance with activities of daily living, and can be cared for in the adult residential care settings listed above.

ALRs with certification to provide Enhanced ALR care may serve people who need chronic assistance from another person with ambulation, transfer, ascending / descending stairs; are dependent on medical equipment and require more than intermittent or occasional assistance from medical personnel; or have chronic, unmanaged urinary or bowel incontinence. ALRs with certification to provide Special Needs ALR care may serve people who have a need for a secured environment and/or highly specialized services due to advanced dementia or other special need.

I certify that I have physically examined this patient and have accurately described the individual's medical condition, medication regimen and need for skilled and/or personal care services. Based on this examination and my knowledge of the patient, this individual:

☐ **IS** ☐ **IS NOT** medically **suited** for care in an adult home or EHP.

☐ **IS** ☐ **IS NOT** mentally s**uited** for care in an adult home or EHP.

☐ **IS** ☐ **IS NOT** in need of continual acute or long term medical or nursing care or supervision which would require placement in a hospital or nursing home.

☐ **IS** ☐ **IS NOT** in need of 24-hour skilled nursing care.

LEVEL OF CARE RECOMMENDATION:

☐ AH / EHP / ALR ☐ Enhanced ALR ☐ Special Needs ALR

Signature:_____ **Date**: _____
(Physician)